SERVICE AGREEMENT/ASSIGNMENT OF BENEFITS

Patient Name: William Griffis

Patient ID Number: _____ Date: 2/28/07

Consent for Treatment
I consent to treatment and services provided by Factor Health Management, LLC (FHM), FCS Pharmacy LLC (FCS) and/or associated contract providers consistent with a plan of care authorized by my physician, FHM care team and myself. All pharmacy services will be authorized by my insurance company. I understand that enrollment is my choice and that I can disenroll at any time.

Consent for Record Retention/Acknowledgement of Receipt of Notice of Privacy Practices/ Patient's Rights and Responsibilities.
I understand that FHM, FCS and its associated contract providers will keep a record of my care. I acknowledge that I have received a copy of: (i) FHM and FCS' HIPAA Notice of Privacy Practices for Personal Health Information, which describes how FHM, FCS and/or associated contract providers may use and disclose the information contained in my record and explains my rights with respect to such information; (ii) FHM's Confidentiality Policy; (iii) a written description of Patient's Rights and Responsibilities; and (iv) FHM's Grievance Procedure.

Assignment of Benefits/Authorization for Payment/ Financial Responsibility
In consideration of services provided by FHM, FCS and its associated contract providers, I hereby assign and transfer to FHM and FCS all rights, title and interest to reimbursement payable to me for services provided by FHM, FCS and its associated contract providers. I agree to immediately turn over to FHM, either by endorsing any check that I receive, or by sending the amount of the payment that I receive, for services rendered by FHM, FCS or its associated contract providers. Under no circumstance shall I retain any such payment.

I request that FHM act on my behalf to submit charges for services rendered by FCS or its associated contract providers and I hereby authorize payment directly to FHM, FCS or its associated contract providers of any benefits otherwise payable for items/services, at a rate not to exceed FHM's regular charges for such items/services. I hereby authorize FHM, FCS or its associated contract pharmacies to bill for services and receive payment directly from my private health insurance, Medicare and/or Medicaid.

I understand that I am responsible for and will pay in full the portion of my bill not covered by insurance companies, governmental agencies or third party payors, including, but not limited to, any applicable co-payments, share of cost payments, deductibles, denials and charges for services not covered by my insurance company, a governmental agency or third party payor, such as charges for services that are determined by such entity not to be medically necessary or not covered under the terms of my health plan. In consideration of services to be provided, I agree to pay FHM and FCS in accordance with the regular rates and terms of each applicable provider. Should the account be referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses.

Relationship between Physician and Factor Health Management
FHM will work with my physician and incorporate my physician's treatment plan within the FHM care plan. I understand that my physician is not an employee or agent or associated in any way with FHM or FCS. FHM, FCS and its associated contract pharmacies shall not be liable for any act or omission of my physician or for following my physician's orders.

Factor Health Management, LLC
Choice, Quality, Community Support
7700 Congress Avenue, Suite #3109, Boca Raton, FL 33487
T#: (866) 322-3461 F#: (561) 981-8804

EXHIBIT
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Signature of Agreement/ Witness

William Griffis Legal Name of Patient	2/28/07 Date
William Griffis Signature of Patient, Parent or Legal Guardian	2/28/07 Date
Tammy Griffis Witness	2/28/07 Date
Signature of FHM/FCS Representative/ Title	Date

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